Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

BONE DENSITY STUDY (DXA) REQUEST

Please complete and fax to: **(603)-640-1944**
For telephone assistance: **(603)-653-9388**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Medicare: ☐ Primary ☐ Secondary Height: _____ **Weight***: _____ lbs MRN:_____

☐ **Patient Ambulatory*** **Date of last DXA Scan*:** _____/_____/_____

Special Considerations:

☐ Blind ☐ O^2
☐ Deaf ☐ Pregnant
☐ Diabetic ☐ **Precautions**
☐ Disoriented ☐ Stretcher Needed
☐ IV ☐ Wheelchair Needed

Patient Special Needs:_____
_____
_____

Clinical History:_____
_____

Pediatric Indication: _____

INDICATION – CHECK ALL THAT APPLY (*Required)

***MEDICARE/NON-MEDICARE INSURANCE COVERED INDICATIONS:** At least 24 months **must** have passed since the last bone mass measurement was performed – Any sooner will require a signed ABN form)

All insurances including Medicare must meet one or more of the covered indications:

☐ Estrogen Deficient (E28.39)
☐ Hyperparathyroidism (E21.3)
☐ Osteopenia (M85.80)
Body Part*: ☐ Spine ☐ Forearm ☐ Hip ☐ Multiple Sites
Laterality*: ☐ Left ☐ Right ☐ Bilateral
☐ Osteoporosis
☐ Age related (M81.0)
☐ Medication Induced (M81.8)

☐ Other Indication**: ICD 10* _____ Code Description*:_____

**If a Medicare patient does not meet at least one of the above indications you MUST have a signed Advanced Beneficiary Notice (ABN)/waiver of payment at the time of scheduling, indicating the understanding that services may not be covered. ABN/Waiver must be signed and faxed with the request to 603-640-1944.

REFERRING PROVIDER

Ordering Facility Name: _____
Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____
Ordering Provider Name (Print): _____
Ordering Provider Signature*: _____ Date: _____/_____/_____

☐ Staff Physician
☐ Resident/Other

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